



MISSISSIPPI DIVISION OF  
**MEDICAID**

Administrative Code

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Title 23: Medicaid  
Part 221  
Family Planning Services

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## **Title 23: Division of Medicaid**

### **Part 221: Family Planning and Family Planning Related Services**

#### **Chapter 1: Family Planning and Family Planning Related State Plan Services**

##### *Rule 1.1: Purpose*

The Division of Medicaid covers family planning and family planning related State Plan services and supplies, directly or under arrangements with others, to individuals capable of reproduction, including minors who can be considered to be sexually active, who are eligible under the State Plan and who desire such services and supplies.

Source: 42 USC §1396a; Miss. Code Ann. § 43-13-121.

##### *Rule 1.2: Freedom of Choice*

- A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services in accordance with Miss. Admin. Code Part 200, Rule 3.6.
- B. Beneficiaries have freedom of choice to:
  - 1. Receive or reject family planning and family planning related services,
  - 2. Choose family planning and family planning related services providers, and
  - 3. Choose any method of birth control, including sterilization.
- C. Beneficiaries must not be coerced to employ or not to employ any particular method of birth control including sterilization.
- D. Providers must ensure that information is given in such a way as to encourage and support freedom of choice.

Source: 42 USC § 1396a; Miss. Code Ann. § 43-13-121.

History: Added Miss. Admin. Code Part 221, Rule 1.2.C, revised eff. 07/01/2015.

##### *Rule 1.3: Beneficiary Cost Sharing*

Family planning and family planning related services are exempt from cost sharing (co-pay) requirements in accordance with Miss. Admin. Code Part 200, Rule 3.7.

Source: 42 USC § 1396a; 42 CFR §§ 447.50-447.57; Miss. Code Ann. § 43-13-121.

##### *Rule 1.4: Covered Services*

- A. Family planning and family planning related services are available for eligible beneficiaries who voluntarily choose to:
  - 1. Prevent pregnancy,
  - 2. Plan the number of pregnancies, or
  - 3. Plan the spacing between pregnancies.
- B. Family planning and family planning related services include, but are not limited to:
  - 1. Contraceptive injections purchased by the provider and administered in the provider's office,
  - 2. Prescription contraceptives dispensed through the pharmacy program,
  - 3. Insertion, removal, and removal with reinsertion of a contraceptive intrauterine device,
  - 4. Insertion, removal, and removal with reinsertion of a contraceptive implant,
  - 5. Diaphragm or cervical cap fitting with instructions,
  - 6. Vaginal rings,
  - 7. Voluntary vasectomy and tubal ligation procedures, including tubal sterilization by hysteroscopy if the criteria in Miss. Admin. Code Part 202, Rule 5.3. is met, and
  - 8. Laboratory procedures, including, but not limited to:
    - a) Papanicolaou (Pap) smears, and
    - b) Screenings for sexually transmitted infections (STIs)/sexually transmitted diseases (STDs).
- C. Counseling and education are considered part of the family planning visit and cannot be billed separately.

Source: 42 USC § 1396a; 42 CFR Part 441, Subpart F; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 07/01/2015; Revised Rule 1.4.B.4. 10/01/2013.

*Rule 1.5: Non-Covered Services and Items*

Services and items not considered family planning and family planning related services include, but are not limited to:

- A. Facilitating services, including, but not limited to, parking and child care while family planning and family planning related services are being obtained,
- B. Indirect services including, but not limited to, telephone contacts/consultations,
- C. Drugs used to promote fertility,
- D. Emergency contraceptives and related services,
- E. Over-the-counter drugs and supplies including, but not limited to, pregnancy tests and spermicides,
- F. Infertility studies and procedures to enhance fertility including, but not limited to, reversal of sterilization, artificial or intrauterine insemination or in-vitro fertilization,
- G. Abortions and related services,
- H. Hysterectomy and related services for sterilization purposes,  
Menopausal or post-menopausal treatment and related services,
- J. Removal of an implanted device for a non-Medicaid eligible individual,
- K. Natural family planning services,
- L. Ultrasound and radiology services,
- M. Cancer screening services, except for Pap smears,
- N. Services to a beneficiary whose age or physical condition precludes reproduction,
- O. Services to a beneficiary known to be pregnant,
- P. Reversal of voluntary sterilization, or
- Q. Services outside the scope and/or authority of the provider's specialty and/or area of practice.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 07/01/2015.

*Rule 1.6: Documentation/Record Maintenance*



- A. Providers of family planning and family planning related services must comply with the requirements for maintenance of records outlined in Miss. Admin. Code Part 200, Rule 1.3.
- B. Documentation of family planning and family planning related services must include, but are not limited to:
  - 1. Signed and dated consent for treatment, if applicable,
  - 2. Signed and dated consent for sterilization, if applicable, as outlined in Miss. Admin. Code Part 202, Rule 5.3.,
  - 3. Date of service and reason for visit,
  - 4. Demographic information, including name, address, Medicaid number, date of birth, sex, and marital status,
  - 5. Comprehensive health history, updated at least annually, including, but not limited to:
    - a) Health risk factors,
    - b) Personal medical, sexual and contraceptive history,
    - c) Plans for having children, and
    - d) Obstetrical and gynecological history.
  - 6. Complete family history, updated at least annually,
  - 7. Allergies, including type, reaction, and treatment,
  - 8. Specific name/type of all diagnostic studies, including, but not limited to, laboratory and the result/finding of the studies,
  - 9. Treatments/procedures rendered,
  - 10. Physical findings including vital signs and weight,
  - 11. Documentation of all medications including contraceptives whether administered by the provider, prescribed, or issued via physician/prescriber samples, and must include, but not limited to:
    - a) The name,
    - b) Strength,
    - c) Dose,

- d) Route of administration,
  - e) Site for all injectables, and
  - f) Manner in which prescription was issued including, but not limited to, in writing, by telephone, electronically or via facsimile.
12. Contraceptive supplies whether administered by the provider, prescribed, or issued via provider/prescriber samples,
  13. Contraceptive devices,
  14. Contraception counseling,
  15. Date, time, and signature for all entries in the beneficiary's record, and
  16. Provider's order, which must include the time, date, and signature, for all medications, treatments, and procedures rendered.

Source: 42 CFR Part 441, Subpart F; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129.

History: Revised eff. 07/01/2015.

*Rule 1.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)*

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Miss. Admin. Code Part 223 without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

*Rule 1.8: Reimbursement*

- A. The Division of Medicaid reimburses for only the provider's actual acquisition cost for physician administered drugs or implantable drug system devices.
- B. The Division of Medicaid does not reimburse for provider/prescriber drug samples.

Source: Miss. Code Ann. § 43-13-121.

History: New Rule eff. 07/01/2015.

**Chapter 2: 1115(a) Family Planning and Family Planning Related Waiver Services**

### *Rule 2.1: Purpose*

- A. The Division of Medicaid covers family planning and family planning related waiver services and supplies, referred to as FPW in Miss. Admin. Code Part 221, Chapter 2, for all women and men, ages thirteen (13) through forty-four (44), who are capable of reproduction, who would not otherwise qualify for Medicaid, and with incomes at or below one hundred eighty-five percent (185%) of the federal poverty level, converted to a Modified Adjusted Gross Income (MAGI) equivalent standard through the 1115(a) Family Planning Waiver (FPW) Demonstration.
- B. Providers are responsible for verification of covered FPW services and participant eligibility under the 1115(a) FPW Demonstration.

Source: Miss. Code Ann. § 43-13-121.

History: Revised Miss. Admin. Code Part 221, Rule 2.1.A. eff. 10/01/2015. Revised to correspond with the Family Planning Waiver renewal (eff. 01/01/2015) eff. 07/01/2015.

### *Rule 2.2: Eligibility*

- A. The FPW limits eligibility to individuals age thirteen (13) through forty-four (44) who meet the following criteria:
  - 1. Individual has a family income at or below one hundred eighty-five percent (185%) of the federal poverty level, converted to a MAGI equivalent.
  - 2. Female individual is not pregnant and has not had a medical procedure that would prevent pregnancy including, but not limited to, tubal ligation procedures, including tubal sterilization by hysteroscopy,
  - 3. Male individual has not had a medical procedure that would prevent reproduction, including, but not limited to, a vasectomy,
  - 4. Individual is uninsured and is not enrolled in Medicare, Medicaid, Children's Health Insurance Program (CHIP) or possesses other health insurance coverage that provides family planning and family planning related services,
  - 5. Individual is a U.S. citizen or documented immigrant, and
  - 6. Individual is a Mississippi resident.
- B. Individuals eligible for the FPW remain eligible for twelve (12) consecutive months, or for the duration of the program if less than one (1) year and must recertify at the end of each year of eligibility.
- C. Women between ages thirteen (13) through forty-four (44) who are eligible for Medicaid



maternity services and have reached the end of their sixty (60) day postpartum period are automatically enrolled in the FPW.

1. A separate application is not required if the individual is uninsured.
2. The individual will be notified by mail of eligibility for services.

D. The participant will lose eligibility when one (1) of the following occurs:

1. Moves from the state of Mississippi,
2. Loses FPW eligibility,
3. Becomes eligible for another Medicaid program, Medicare, or obtains health insurance with family planning and family planning related benefits,
4. Requests closure or termination of FPW services,
5. Has a procedure that prevents reproduction, including, but not limited to, a tubal ligation procedure, including tubal sterilization by hysteroscopy, or a vasectomy,
6. Becomes pregnant,
7. Turns forty-five (45) years of age, or
8. Is deceased.

E. FPW applicants are considered only for eligibility in the FPW; however, an application for full Medicaid benefits may be filed at any time.

Source: 42 USC §§ 1315, 1396; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised Miss. Admin. Code Part 221, Rule 2.2.A.1. eff. 10/01/2015. Revised to correspond with the Family Planning Waiver renewal (eff. 01/01/2015) eff. 07/01/2015.

*Rule 2.3: Freedom of Choice*

- A. Participants have the right to freedom of choice of providers for FPW services in accordance with Miss. Admin. Code Part 200, Rule 3.6.
- B. Beneficiaries have freedom of choice to:
  1. Receive or reject FPW services,
  2. Choose FPW providers, and

3. Choose any method of birth control, including sterilization.
- C. Participants must not be coerced to employ or not to employ any particular method of birth control, including sterilization.
- D. Providers must ensure that information is given in such a way as to encourage and support freedom of choice.

Source: 42 USC § 1396a; Miss. Code Ann. § 43-13-121.

*Rule 2.4: Covered Services*

FPW services are available for eligible participants who voluntarily choose to:

1. Prevent pregnancy,
  2. Plan the number of pregnancies, or
  3. Plan the spacing between pregnancies.
- B. FPW services are limited to four (4) visits annually between October 1 through September 30 and include:
1. A one (1) time initial visit defined as the first time a participant receives family planning services from a provider and must include, but is not limited to:
    - a) The establishment of a medical record,
    - b) An in-depth evaluation including a complete medical history,
    - c) A complete physical examination,
    - d) Establishment of baseline laboratory data,
    - e) FPW services counseling and education which includes contraceptive and sexually transmitted disease prevention, and
    - f) Issuance of supplies or prescriptions.
  2. An annual visit defined as the re-evaluation of an established participant the next year following the one (1) time initial evaluation and must include, but is not limited to:
    - a) An update to the medical record,
    - b) Interim history,

- c) Complete physical examination,
  - d) Appropriate diagnostic lab tests or procedures,
  - e) FPW services management, education and counseling, and
  - f) Renewal or change of FPW services prescriptions or supplies.
3. A follow-up visit is defined as an evaluation of an established participant with a new or existing family planning or family planning related issue, and must include, but is not limited to:
- a) An evaluation of the participant's contraceptive program,
  - b) Renewal or change of the contraceptive prescription or supplies, and
  - c) Additional opportunities for counseling and education regarding reproductive health and family planning and family planning related issues.

C. FPW only covers the following drugs:

- 1. Oral contraceptive agents,
- 2. Topical patches,
- 3. Self-inserted contraceptive products,
- 4. Injectable contraceptives dispensed in the pharmacy venue and administered in the provider's office,
- 5. Contraceptive injections purchased by the provider and administered in the provider's office,
- 6. Medications for the treatment of a STI/ STD identified or diagnosed during a routine or periodic FPW visit except for human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS) and hepatitis, and
- 7. Medications and/or treatments for vaginal infections or disorders, other lower genital tract and genital skin infections or disorders, and urinary tract infections when these conditions are identified or diagnosed during a routine or periodic FPW visit.

D. Covered contraceptive devices include:

- 1. Insertion, removal, and removal with reinsertion of a contraceptive intrauterine device,
- 2. Insertion, removal, and removal with reinsertion of a contraceptive implant,

- 3. Diaphragm or cervical cap fitting with instructions, and
- 4. Vaginal rings.
- E. Voluntary vasectomy and tubal ligation procedures, including tubal sterilization by hysteroscopy, if the criteria in Miss. Admin. Code Part 202, Rule 5.3 is met.
- F. Laboratory procedures that must be conducted during initial and annual visits include the following:
  - Hemoglobin,
  - Urinalysis,
  - Pap smear as indicated according to the participant's needs,
  - Screenings for STI/STD and HIV/AIDS, and
  - Pregnancy test, as indicated.

Source: 42 USC §§ 1315, 1396; 42 CFR Part 441, Subpart F; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the Family Planning Waiver renewal (eff. 01/01/2015) eff. 07/01/2015.

*Rule 2.5: Non-Covered Services and Items*

Services and items not considered FPW services and not reimbursable under the waiver program and include, but are not limited to, the following:

- A. Facilitating services including, but not limited to, transportation, parking, and child care while FPW services are being obtained,
- B. Indirect services, including, but not limited to, telephone contacts/consultations,
- C. Drugs used to promote fertility,
- D. Emergency contraceptives and related services,
- E. Over-the-counter drugs and supplies including, but not limited to, pregnancy tests and spermicides,
- F. Infertility studies and procedures to enhance fertility including, but not limited to, reversal of sterilization, artificial or intrauterine insemination or in-vitro fertilization,



- G. Abortions and related services,
- H. Hysterectomy and related services for sterilization purposes,
- I. Menopausal or post-menopausal treatment and related services,
- J. Removal of an implanted device for a non-FPW eligible individual,
- K. Natural family planning services,
- L. Ultra sounds and radiology services, except for vaginal ultrasounds,
- M. Cancer screening services, except for Pap smears,
- N. Mammograms,
- O. Services to a participant whose age or physical condition precludes reproduction,
- P. Services to a participant known to be pregnant,
- Q. Reversal of voluntary sterilization,
- R. Services outside the scope and/or authority of the provider's specialty and/or area of practice,
- S. Inpatient hospital visit,
- T. All services provided for the treatment of a medical condition not considered family planning or family planning related,
- U. Services for participants who have received a sterilization procedure and have completed all necessary follow-up procedures, and
- V. Prescriptions other than contraceptives and medications to treat STI/STD, vaginal infections or disorders, other lower genital tract and genital skin infections or disorders, and urinary tract infections.

Source: 42 USC §§ 1315, 1396; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with the Family Planning Waiver renewal (eff. 01/01/2015) eff. 07/01/2015.

*Rule 2.6: Quality Assurance*

A. The Quality Assurance Plan:

1. Ensures the provision of comprehensive, accessible, quality and appropriate FPW services,
  2. Provides a system for accountability and measuring performance, and
  3. Improves care outcomes and quality of life.
- B. The Division of Medicaid in conjunction with the Mississippi State Department of Health (MSDH) monitors quality and improvement activities for MSDH clinics to:
1. Ensure standards of care for FPW services utilize evidence-based best practices, and
  2. Conduct periodic on-site review of medical records.
- C. The Division of Medicaid conducts periodic on-site reviews of medical records to determine that participants have received appropriate medical care and are appropriately referred for needed primary care.

Source: Miss. Code Ann. § 43-13-121.

*Rule 2.7: Participant Cost Sharing*

FPW services are exempt from cost sharing (co-pay) requirements in accordance with Miss. Admin. Code Part 200, Rule 3.7.

Source: 42 USC § 1396a; 42 CFR §§ 447.50-447.57; Miss. Code Ann. § 43-13-121.

*Rule 2.8: Primary Care Referrals*

- A. Health concerns identified during a FPW visit but not covered by the FPW must be followed up by a primary care provider with an appropriate clinical referral.
- B. Providers should refer participants to other social service and healthcare providers as medically indicated including, but not limited to, a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).
- C. As a component of the medical record audit, the primary care referral must be documented in the participant's medical record.

Source: Miss. Code Ann. § 43-13-121.

*Rule 2.9: Documentation/Record Maintenance*

- A. Providers of FPW services must comply with the requirements for maintenance of records outlined in Miss. Admin. Code Part 200, Rule 1.3.
- B. FPW services documentation must include, but is not limited to:

1. Date of service,
2. Reason for visit,
3. Physical findings including vital signs and weight,
4. Treatments/procedures rendered,
5. Demographic information, including name, address, Medicaid number, date of birth, sex, and marital status,
6. Allergies, including type, reaction and treatment,
7. Comprehensive health history, updated at least annually, including, but not limited to:
  - a) Health risk factors,
  - b) Personal medical, sexual and contraceptive history,
  - c) Plans for having children, and
  - d) Obstetrical and gynecological history.
8. Complete family history, updated at least annually,
9. Specific name/type of all diagnostic studies, including, but not limited to, laboratory and the result/finding of the studies,
10. Documentation of all medications including contraceptives, whether administered by the provider, prescribed, or issued via samples and must include:
  - a) The name,
  - b) Strength,
  - c) Dose,
  - d) Route of administration,
  - e) Site for all injectables, and
  - f) Manner in which prescription was issued including, but not limited to, in writing, by telephone, electronically or via facsimile.
11. Contraceptive supplies whether administered by the provider, prescribed, or issued via samples,

12. Contraceptive devices,
13. Contraception counseling,
14. Date, time, and signature for all entries in the participant's record,
15. Provider's order, which must include the time, date, and signature for all medications, treatments and procedures rendered,
16. Signed and dated consent for treatment, as applicable,
17. Primary care referrals, if applicable, and
18. Signed and dated consent for sterilization, if applicable, as outlined in Miss. Admin. Code Part 202, Rule 5.3.

Source: 42 CFR Part 441, Subpart F; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129.

History: Revised to correspond with the Family Planning Waiver renewal (eff. 01/01/2015) eff. 07/01/2015.

*Rule 2.10: Reimbursement*

- A. The Division of Medicaid reimburses for only the provider's actual acquisition cost for physician administered drugs or implantable drug system devices.
- B. The Division of Medicaid does not reimburse for provider/prescriber drug samples.

Source: Miss. Code Ann. § 43-13-121.

History: New Rule eff. 07/01/2015.